

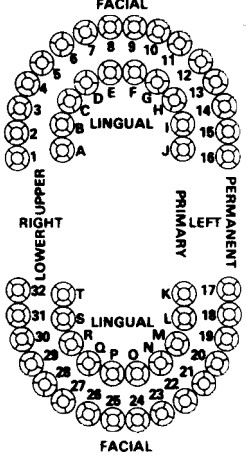
Dental Claim Form

Check one: <input type="checkbox"/> Dentist's pre-treatment estimate <input type="checkbox"/> Dentist's statement of actual services				Carrier name and address 			
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PATIENT COVERAGE INFORMATION	1. Patient name first m.i last		2. Relationship to employee <input type="checkbox"/> self <input type="checkbox"/> child <input type="checkbox"/> spouse <input type="checkbox"/> other _____		3. Sex m f	4. Patient birthdate MM DD YYYY	5. If full time student school city	
	6. Employee/subscriber name and mailing address		7. Employee/subscriber soc. sec. or I.D. number	8. Employee/subscriber birthdate MM DD YYYY		9. Employer (company) name and address		10. Group number
	11. Is patient covered by another dental plan? yes no If yes, complete 12-a. Is patient covered by a medical plan? yes no		12-a. Name and address of carrier(s)		12-b. Group no.(s)		13. Name and address of other employer(s)	
	14-a. Employee/subscriber name (if different than patient's)		14-b. Employee/subscriber soc. sec. or I.D. number		14-c. Employee/subscriber birthdate MM DD YYYY		15. Relationship to patient <input type="checkbox"/> self <input type="checkbox"/> parent <input type="checkbox"/> spouse <input type="checkbox"/> other _____	

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.				I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.			
Signed (Patient, or parent if minor) _____ Date _____				Signed (insured person) _____ Date _____			

BILLING DENTIST	16. Name of Billing Dentist or Dental Entity				24. Is treatment result of occupational illness or injury? No Yes		If yes, enter brief description and dates.	
	17. Address where payment should be remitted City, State, Zip				25. Is treatment result of auto accident? No Yes		If yes, enter brief description and dates.	
	18. Dentist Soc. Sec. or T.I.N.				19. Dentist license no.		20. Dentist phone no.	
	21. First visit date current series				22. Place of treatment Office Hosp. ECF Other		23. Radiographs or models enclosed? No Yes How many?	
	27. If prosthesis, is this initial placement?				26. Other accident? No Yes		(If no, reason for replacement) 28. Date of prior placement	

Identify missing teeth with "x" 	30. Examination and treatment plan - List in order from tooth no. 1 through tooth no. 32 - Use charting system shown.							For administrative use only				
	Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year			Procedure Number	Fee				
31. Remarks for unusual services												

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.				Total Fee Charged			
Signed (Treating Dentist) _____ License Number _____ Date _____				Max. Allowable			
				Deductible			
				Carrier %			
				Carrier pays			
				Patient pays			